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## Executive summary

### Claims activity:

#### *New and paid claims drop substantially*

■ **New claims against medical providers fell more than 14 percent in 2003, reaching a record low.** The number of claims against physicians fell 11 percent, almost matching the lows registered in 2001, 1998 and 1997. New claims against hospitals continued a steady decline since 1991, falling 12.8 percent last year. The number of new claims provides a gauge of future costs that should affect current rates.

■ **Claims closed against all providers with payment fell to the second lowest level ever – 504, compared to the all-time low of 455 in 2000.** Last year's total fell 12.5 percent from 2002.

■ **Claims closed against physicians with payment fell to the second lowest level on record.** Only the 158 claims paid in 2001 were lower than the 184 last year. The 2003 total fell 20.3 percent from 2002.

■ **Claims closed against hospitals with payment reached 124, or about the norm since 1998, when a steep decline began leveling out.** By contrast, paid claims against hospitals totaled 227 in 1989.

### Claims payments:

#### *Steep reductions occur in actual losses*

■ **Payouts to malpractice victims dropped substantially in 2003.** Insurers' overall benefits paid to malpractice victims dropped from \$118.7 million to \$93.5 million last year, or by 21 percent. The decline in payouts produced the lowest cash-flow ratio – the percentage of revenues actually paid in benefits – since 1994. Malpractice insurers paid out 45 cents of each premium dollar in coverage written in 2003 while unlicensed but legal surplus lines insurers paid out only 24 cents. Such low levels usually signal that rate hikes are overshooting losses as an insurance cycle peaks; normal cash-flow levels are in the 60 percent range.

■ **Insurers' payouts to victims of physician malpractice dropped more steeply,** from \$79.4 million to \$52.9 million, or by 33 percent. The payout dropped to 39 cents for every \$1 written in physicians' policies.

■ **The size of average awards stayed essentially flat in 2003, rising less than 2 percent to \$211,502.** The typical or median award payment in Missouri is lower -- \$125,000. Average awards have stayed on a plateau since 2000, when they jumped dramatically. Average awards rose 8.1 percent last year for claims against physicians; higher economic damages for lost wages and future medical care accounted for all but \$3,050 of the \$18,253 increase in average 2003 awards against physicians.

■ **A statistical analysis of average payments shows that the entire increase since 1990 has been accounted for by medical inflation, average wages (lost income) and the increasing severity of injuries suffered by patients.** In 1990, the average claims payment was \$99,621. If wage and medical inflation and injury severity since then are considered, the expected average in 2003 would have been \$209,519; instead, it was a virtually identical \$211,502.

- **The number of \$1 million-plus awards remained at eight in 2003, or the usual number dating back to 1992.** The high was 11 in 1996. Three awards, all involving hospitals, exceeded \$2 million last year.
- **The growth of premiums is far outstripping actual losses.** Insurance premiums paid by physicians jumped 121 percent from 2000 (\$61.4 million) to 2003 (\$136.4 million), while actual payments to injured patients rose only 14 percent. All providers' malpractice insurance premiums doubled from 2000 (\$113.5 million) to 2003 (\$227 million). Actual payouts for claims against all providers rose more slowly during that period, from \$70.6 million in 2000 to \$93.5 million, or by 32 percent.
- **The 2002 Scott decision – which created holes in Missouri's cap on noneconomic damages – continued to have a minimal impact on payouts.** That court ruling created the possibility of more than one cap per malpractice case. Insurance company lobbyists originally raised the prospect that overall losses could double or triple. However, claims reports indicated that the Scott case only affected nine cases last year that involved \$3.1 million, or 1.7 percent of premiums and 3.3 percent of losses. Based on insurer evaluations, the typical case involved death, quadriplegia or severe brain damage with the need for lifetime care and/or a terminal diagnosis. In 2002, the ruling increased payments on 12 claims by \$2.6 million, or 1.5 percent of premiums and 2.2 percent of total losses. The Scott decision is the only major change in how Missouri courts and insurers settle claims in almost two decades.

### **Estimated or incurred losses hold steady at near-record levels**

- **Insurers maintained a sharp increase in their *estimates* of what they eventually will pay for new claims, despite indicators to the contrary in 2003.** In 2001, licensed insurers in Missouri estimated future losses of \$65.1 million for claims filed that year – but the total jumped to \$167.9 million in 2002 and \$164.3 million in 2003. (These totals also can reflect revised estimates for claims in previous years.) Insurers consequently increased their incurred loss ratio – or estimated payments on current claims as a percentage of current year's revenues – from 81 percent in 2001 to 108 percent in 2002 to 97 percent last year.
- **Insurers' performance on physician business was much improved in 2003.** Thanks to the \$26.6 million drop in actual payouts and substantial increase in premiums, the cash-flow ratio dropped to only 39 cents in payouts on the premium dollar. The incurred loss ratio, based on *estimates* of future payments, fell from 117 to 90 percent in 2003.

### **Injury severity**

- **The average paid claim in 2003 involved a permanent, “significant” injury such as deafness, loss of a limb or loss of an organ,** based on insurance company evaluations of the claims. The rating continues the general increase in disability for paid claims over the past 15 years. For paid claims involving physicians, the injuries were more severe.
- **The number of deaths involved in paid claims dropped substantially from record levels in 2002.** In 2003, claims with deaths reached 166, compared to 209 the previous year, or a decline of 21 percent.

### **Other trends**

■ **After two years of steady premium hikes, health care providers began moving to unlicensed carriers, known as “surplus lines” insurers, in 2003.** These unlicensed, but legal insurance companies accounted for 18 percent of sales in 2003 versus 13 percent the prior year. Earned premium doubled from 2002 to 2003. Policyholders go to surplus lines companies when they can no longer find coverage in the regular commercial market. MDI activated a state-sponsored insurance plan in June to help provide coverage for physicians and other providers who cannot buy regular policies. But because of legal restrictions on that state-sponsored plan, only three physicians had bought its coverage through the end of September; most of the plan’s business so far has involved policies for nursing facilities.

■ **In inflation-adjusted dollars, gross malpractice insurance premiums for physicians now equal the level seen in 1990, although the number of practicing doctors has increased substantially.** The \$121.3 million paid in 2003 compares to an inflation-adjusted \$120.8 million in 1990 and \$134.4 million in 1989.

■ **Unlike with most insurance lines, three-fourths of malpractice claims result in a lawsuit.** The litigation percentage exceeds 81 percent for physicians.

■ **Few malpractice lawsuits result in verdicts by a judge or jury.** Only 5.3 percent of all such cases reach resolution in court; the remainder result in settlements or dismissals.

■ **The average victim waits 47 months, or four years, to receive an award for malpractice after the medical error occurs.** The delay is longer for cases involving physicians – 54 months, or 4½ years.

## **Background**

The report is based upon data provided by insurers and self-insured hospitals to the Missouri Department of Insurance. The information draws on open and closed claims data that insurance companies and self-insured hospitals are required to report under Section 383.115 RSMo. The department makes every possible effort to make sure this data is accurate; however, the accuracy of this report still depends largely upon the accuracy of the data filed by the insurers and self-insured hospitals.

Additional information in Section VII was derived from the Page 15 supplement to the annual statement that companies are required to file. This section includes data for the past three years on type of business, company, volume of business, market share and loss ratios.

Data for physicians and surgeons, hospitals and other medical care providers are summarized in this report. Other medical care providers include — but are not limited to — dentists, nurses, nursing homes, chiropractors, pharmacies, optometrists, podiatrists/chiropodists, clinics and corporations.

The Missouri Medical Malpractice Insurance Report is available at the Missouri State Library and in major depository libraries in the state. Copies are available in Braille, large print or audio cassettes upon request.

Address questions on this report to the Statistics Section, Missouri Department of Insurance, P.O. Box 690, Jefferson City MO 65102-0690.

# Section I

## Major Historical Trends

This section contains graphs depicting trends in the medical malpractice insurance for:

- All medical care providers
- Physicians & Surgeons only
- Hospitals only

The tables and graphs are further categorized by:

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## **Section II**

### **Claim Severity**

This section classifies individual claim data based on the amount of indemnity paid. The data are divided into summaries of All Medical Care Providers, Physicians and Hospitals for the years 2001, 2002 and 2003. Summaries include:

- Average Number of Months from Occurrence to Close
- Number of Claims Reported and Closed
- Cumulative Percentage of Number of Claims on Claims Closed
- Total Indemnity Paid on all Closed Claims
- Cumulative Percentage of Indemnity Paid on Claims Closed
- Average Economic Damage Paid on Closed Claims
- Average Non-economic Damage Paid on Closed Claims
- Average Indemnity Paid per Defendant (Excludes LAE)
- Average Loss Adjustment Expense Paid per Defendant

The following terms are used in subsequent tables:

- Economic damages: damages arising from monetary harm including medical bills, loss wages and lost earning capacity. (Unlimited in amount).
- Non-Economic damages: damages arising from non-monetary harm including mental anguish, inconvenience, physical impairment, disfigurement, loss of capacity to enjoy life and loss of consortium. (Malpractice insurance does not insure punitive damages.)
- Loss Adjustment Expenses: includes expenses paid to defense counsel and all other allocated loss adjustment expenses, including filing fees, telephone charges, photocopy fees, expenses of defense counsel, etc.

## **Section III**

# **Claim Severity by Injury Severity And Lapsed Time to Disposition**

This section illustrates the paid claim count, the average paid indemnity (economic + non-economic), the percent change of paid claims, and the percent change of the average paid indemnity by bodily injury severity for the past four years. These tables are displayed by the major business classifications and by the months from incident to disposition for all medical care providers, physicians and hospitals. The following define the severity categories:

- **Severity 1, 2, 3, 4** - emotional distress, insignificant or temporary injury, including contusions, minor scars, infections, fracture, burns, drug side effect.
- **Severity 5, 6, 7, 8** - permanent injuries, such as loss of limb, damage to organs, deafness, blindness, brain damage, paraplegia.
- **Severity 9** - death.

## **Section IV**

### **Indemnity Analysis by Company**

Section IV contains the total number of claims reported to the insurer, total number of closed claims, the number of claims closed with payment, the total indemnity paid (economic + non-economic), the total economic damage paid and the total non-economic damage paid by each company and self-insured hospital reporting closed claim data.

The past three years are recorded separately and the companies are listed in descending order by the number of paid claims.

## **Section V**

### **Indemnity Analysis by Professional Specialty**

This exhibit contains the total number of claims reported to the insurer, total number of closed claims, the number of claims closed with payment, the total indemnity paid (economic + non-economic), the total economic damage paid and total non-economic damage paid by profession specialty code. The profession specialty code is a uniform rating/underwriting code developed by Insurance Services Office (ISO).

The data are ranked in descending order by the total number of paid claims closed for the past three years (2001 through 2003).

## **Section VI**

### **Claim Study by Means of Disposition**

This section contains a thorough claim study by means of disposition. We have two exhibits containing the claim study by means of disposition for physicians and surgeons and for hospitals. Within each disposition type the following data is presented:

- Number of Claims Closed
- Percentage of Claims by Means of Disposition
- Average Number of Months from Incident to Report
- Average Number of Months from Incident to Disposition
- Average Bodily Injury Severity (Severity codes defined in Section III)
- Average Economic Damage Paid per Claim
- Average Non-Economic Damage Paid per Claim
- Average Total Indemnity Paid per Claim (Economic + Non-Economic)
- Average Loss Adjustment Expense Paid per Claim

## **Section VII**

### **Market Share and Experience Data by Company**

This section contains the written premium, earned premium, paid losses, incurred losses, market share and loss ratio of all Medical Malpractice writers in Missouri. The data was derived from the Page 15 Supplement of the Annual Statement. In addition to a total for medical malpractice insurance, the data is broken down into five categories of malpractice insurance:

- Physicians & Surgeons
- Hospitals
- Dentists
- Nurses
- All Other

The reports are presented in descending order of market share by company. The data for this exhibit is independent of the closed claim data used in all preceding tables.

## **Section VIII**

### **Trends Excluding Self Insureds**

This section contains graphs depicting trends in the medical malpractice insurance market excluding the self insureds for:

- All medical care providers
- Physicians & Surgeons only
- Hospitals only

The tables and graphs are further categorized by:

- Claim count
- Closed claim count
- Average indemnity paid
- Impact of medical malpractice awards

# Definition of Terms

**Cash Flow Loss Ratio** – Direct paid losses divided by direct written premium.

**Economic Damages** – The amount of damages arising from pecuniary harm including, without limitation, medical damages and those damages arising from lost wages and lost earning capacity.

**Direct Incurred Losses** – Total indemnity costs of insured claims, including both sums already paid and estimates of those yet to be paid, before reinsurance has been ceded and/or assumed.

**Direct Losses Paid** – Total indemnity costs of insured claims, including amounts paid in the current year for claims arising from coverage in prior years, before reinsurance has been ceded and/or assumed.

**Direct Premium Earned** – The part of premiums attributable to the coverage already provided in a given period before reinsurance has been ceded, and/or assumed.

**Direct Premium Written** – Amount charged when a policyholder contracts for insurance coverage before reinsurance has been ceded and/or assumed.

**Loss Ratio** – Direct incurred losses divided by direct earned premium.

**Non-Economic Damages** – The amount of damages arising from non-pecuniary harm including, without limitation, pain, suffering, mental anguish, inconvenience, physical impairment, disfigurement, loss of capacity to enjoy life and loss of consortium.

**Non-Admitted Market** – Sales by surplus lines carriers and risk retention groups. Surplus lines carriers have no Missouri license, and MDI does not approve policy forms or review rates. These insurers, however, have a license in at least one state and have demonstrated the financial ability to write policies for hard-to-obtain coverage in Missouri. Risk retention groups – whose members have similar needs for liability coverage – are organized under federal law and exempt from regulation except by the state that they chose as the domicile for their license.